

# ATTACHMENT 2

## Sample CMS 1500 Claim Form for End-Stage Renal Disease-Related Services (Recipient Other Than Home Dialysis)

HEALTH INSURANCE CLAIM FORM																																																																																																																																																																																																																																																
<div style="display: flex; justify-content: space-between;"> <div> <div style="display: flex; align-items: center;"> <input type="checkbox"/> PICA         </div> <div>           1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/> </div> </div> <div> <div style="display: flex; align-items: center;"> <input type="checkbox"/> (Medicare #)           <input checked="" type="checkbox"/> (Medicaid #)           <input type="checkbox"/> (Sponsor's SSN)           <input type="checkbox"/> (VA File #)           <input type="checkbox"/> (SSN or ID)           <input type="checkbox"/> (SSN)           <input type="checkbox"/> (ID) </div> </div> <div> <div style="display: flex; align-items: center;"> <div>1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)</div> <div>1234567890</div> </div> </div> </div>																																																																																																																																																																																																																																																
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) <b>Recipient, Im A.</b>				3. PATIENT'S BIRTH DATE MM DD YY <b>02 10 96</b> SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		4. INSURED'S NAME (Last Name, First Name, Middle Initial)																																																																																																																																																																																																																																										
5. PATIENT'S ADDRESS (No., Street) <b>609 Willow St</b>				6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street)																																																																																																																																																																																																																																										
CITY <b>Anytown</b>		STATE <b>WI</b>		8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>		CITY		STATE																																																																																																																																																																																																																																								
ZIP CODE <b>55555</b>		TELEPHONE (Include Area Code) <b>(xxx) xxx-xxxx</b>		Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>		ZIP CODE		TELEPHONE (INCLUDE AREA CODE) ( )																																																																																																																																																																																																																																								
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)				10. IS PATIENT'S CONDITION RELATED TO:		11. INSURED'S POLICY GROUP OR FECA NUMBER																																																																																																																																																																																																																																										
a. OTHER INSURED'S POLICY OR GROUP NUMBER				a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO		a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>																																																																																																																																																																																																																																										
b. OTHER INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>				b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State)		b. EMPLOYER'S NAME OR SCHOOL NAME																																																																																																																																																																																																																																										
c. EMPLOYER'S NAME OR SCHOOL NAME				c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		c. INSURANCE PLAN NAME OR PROGRAM NAME																																																																																																																																																																																																																																										
d. INSURANCE PLAN NAME OR PROGRAM NAME				10d. RESERVED FOR LOCAL USE		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, return to and complete item 9 a-d.																																																																																																																																																																																																																																										
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.																																																																																																																																																																																																																																																
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.  SIGNED _____ DATE _____						13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.  SIGNED _____																																																																																																																																																																																																																																										
14. DATE OF CURRENT: <input type="checkbox"/> ILLNESS (First symptom) OR <input type="checkbox"/> INJURY (Accident) OR <input type="checkbox"/> PREGNANCY(LMP) MM DD YY				15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY																																																																																																																																																																																																																																										
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE				17a. I.D. NUMBER OF REFERRING PHYSICIAN		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																																																																																																																																																																																																																																										
19. RESERVED FOR LOCAL USE						20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES																																																																																																																																																																																																																																										
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. <b>585</b>						22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.																																																																																																																																																																																																																																										
2. _____						23. PRIOR AUTHORIZATION NUMBER																																																																																																																																																																																																																																										
3. _____						4. _____																																																																																																																																																																																																																																										
<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th colspan="2">A</th> <th colspan="2">B</th> <th colspan="2">C</th> <th colspan="2">D</th> <th colspan="2">E</th> <th colspan="2">F</th> <th colspan="2">G</th> <th colspan="2">H</th> <th colspan="2">I</th> <th colspan="2">J</th> <th colspan="2">K</th> </tr> <tr> <th colspan="2">DATE(S) OF SERVICE</th> <th colspan="2">To</th> <th colspan="2">Place of Service</th> <th colspan="2">Type of Service</th> <th colspan="2">PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)</th> <th colspan="2">DIAGNOSIS CODE</th> <th colspan="2">\$ CHARGES</th> <th colspan="2">DAYS OR UNITS</th> <th colspan="2">EPSDT Family Plan</th> <th colspan="2">EMG</th> <th colspan="2">COB</th> <th colspan="2">RESERVED FOR LOCAL USE</th> </tr> <tr> <th>MM</th><th>DD</th><th>YY</th><th>MM</th><th>DD</th><th>YY</th><th></th><th></th><th></th><th></th><th></th><th></th><th></th><th></th><th></th><th></th><th></th><th></th><th></th><th></th><th></th><th></th><th></th><th></th> </tr> </thead> <tbody> <tr> <td>06</td><td>01</td><td>04</td><td></td><td></td><td></td><td>22</td><td></td><td></td><td>G0312</td><td></td><td>1</td><td>XXX</td><td>XX</td><td>1.0</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>12345678</td> </tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> </tbody> </table>										A		B		C		D		E		F		G		H		I		J		K		DATE(S) OF SERVICE		To		Place of Service		Type of Service		PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)		DIAGNOSIS CODE		\$ CHARGES		DAYS OR UNITS		EPSDT Family Plan		EMG		COB		RESERVED FOR LOCAL USE		MM	DD	YY	MM	DD	YY																			06	01	04				22			G0312		1	XXX	XX	1.0								12345678																																																																																																																																										
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25. FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/> <input type="checkbox"/>				26. PATIENT'S ACCOUNT NO. <b>1234JED</b>		27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ <b>XXX XX</b>		29. AMOUNT PAID \$ <b>XX XX</b>		30. BALANCE DUE \$ <b>XX XX</b>																																																																																																																																																																																																																																				
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) <b>J.M. Williams</b> MM/DD/YY						32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)																																																																																																																																																																																																																																										
SIGNED _____ DATE _____						33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # <b>I.M. Billing</b> <b>1 W. Williams</b> <b>Anytown, WI 55555</b> <b>87654321</b> PIN# GRP#																																																																																																																																																																																																																																										

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)